

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1830

## 1. PLACE OF DEATH:

County Hartford  
 City or town White Hall Ind. Rural  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Hartford  
 City or town Blacks Home  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Andrew Lemmon Anderson

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Louella Gibson

## 6. (c) If alive, give age

86 years

## 7. Birth date of

deceased (mo., day, yr.) Aug. 7, 1958

## 8. AGE:

Years

88

Months

0

Days

25

If less than one day

hrs.

min.

## 9. Birthplace

Hartford Co.

(Town, county, and state)

## 10. Usual occupation

Retired Merchant Farmer

## 11. Industry or business

## 12. Name

William Anderson

## 13. Birthplace

Baltimore Co. Ind

## 14. Maiden name

Elizabeth Lemmon

## 15. Birthplace

Hartford Co.

## 16. Informant

Thos J. Ross Wiley

## Address

White Hall Ind

## 17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Sept 4-1946

(month) (day) (year)

## Cemetery or crematory

Bethel

## Location

White Hall RFD

## 18. Funeral director

Harold S. Mahlen

## Address

White Hall Ind

## 19. Date rec'd by registrar

Sept 4 1946 Thomas R. Brown

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Sept 219 46 at 10:59 AM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940

19

to

Sept 219 46

and that I last saw him alive on

Sept 1st19 46

## Immediate cause of death

coronary thrombosis

## DURATION

2 days

## Due to

Valvular heart disease6 years

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Wm. B. Bostner M.D.

M. D. or other

Address

White HallDate signed Sept 4, 46

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DEC 24 1946

BUREAU V B

2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09050 182

1. PLACE OF DEATH: Harford  
County White Boall Rural  
City or town (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Harford County White  
City or town Boall Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) If veteran, name war no

3. (a) FULL NAME Emma Anderson

3. (b) Social Security Number no

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Walter Anderson  
alive 6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Sept. 6, 1897  
8. AGE: Years 49 Months no Days 4 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Grayson Co., Va  
(Town, county, and state)  
10. Usual occupation House work at home

11. Industry or business

12. Name Charles Jennings

13. Birthplace Grayson Co., Va.

14. Maiden name Matilda Hampton

15. Birthplace Grayson Co., Va

16. Informant Walter Anderson

Address White Hall Md.

17. Buried Date thereof Sept 12 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. John's

Location Harford Co., Md.

18. Funeral director St. J. Bailey

Address Arlington, Md.

19. 9/10 19 46 Twicella Fourwood  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1946 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 1945 to Sept 10, 1946

and that I last saw him alive on Sept. 9, 1946

Immediate cause of death Metastatic carcinoma

DURATION 4 yrs.

Due to Carcinoma of Left Breast

Due to 3 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Pregnancy in Left Breast lump Date of op. April 1943

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Charles A. Neff MD.

Address Street, Md. Date signed 9-10-46

MARGIN RESERVED FOR BINDING

VS A15

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09051

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County..... *Hartford*  
 City or town..... *Creswell RD*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... *50 years*  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... *Md* County..... *Hartford*  
 City or town..... *Creswell Rural*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*ANNIE ELIZABETH BEATTY*

## 3. (b) Social Security Number

## 4. Sex

*F*

## 5. Color or race

*W*

## 6. (a) Single, married, widowed, or divorced

*M*

## 6. (b) Name of husband or wife

*Robt Beatty*

## 7. Birth date of deceased (mo., day, yr.)

*Unknown*

## 6. (c) If alive, give age.....

*86* years

## 8. AGE:

Years

Months

Days

If less than one day

*88*

.....hrs. ....min.

## 9. Birthplace

*Baltimore, Md*  
(Town, county, and state)

## 10. Usual occupation

*Home wife*

## 11. Industry or business

FATHER

## 12. Name

*Walter*

## 13. Birthplace

*Balt., Md*

MOTHER

## 14. Maiden name

*UNKNOWN*

## 15. Birthplace

*UNKNOWN*

## 16. Informant

*Robt Beatty*

## Address

*Bel Air md*

## 17.

*Burial*  
(Burial, cremation, or removal, Which?)

## Date thereof

*Sept 23/46*  
(month) (day) (year)

## Cemetery or crematory

*Mount Zion*

## Location

*Forest Green Hartford Co., Md*

## 18. Funeral director

*Dean & Jeter*

## Address

*Bel Air md*

## 19.

*9/25*  
(Date rec'd by registrar)

19

*46 Piscilla Howard*  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *23 SEPTEMBER* 19... *46* at *7:55 P. M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*6 SEPT.* 19... *46* to *23 SEPT.* 19... *46*and that I last saw him/her... alive on *23 SEPT.* 19... *46*Immediate cause of death..... *CEREBRAL HEMORRHAGE*

## DURATION

*3 DAYS*Due to..... *HYPERTENSIVE CARDIO-  
VASCULAR DISEASE**OVER 10 YRS*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

*Robert A. Beatty M.D.*  
M. D. or otherAddress..... *Forest Hill, Md.* Date signed *9/24/46*

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SEP 28 1946

BUREAU V.S.

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OFFICIAL CORPORATE LIMITED CO

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

09052

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH:</b> County <u>Harford</u> City or town <u>Harrods Creek</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>about 8 yrs.</u> Hospital, institution, or street address where death occurred: _____ How long in hospital or institution? _____		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Harford</u> City or town <u>Harrods Creek</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>519 S. Stokes</u> (If rural, give LOCATION) 2.(a) if veteran, name war _____	
<b>3. (a) FULL NAME</b> <u>Jay Byrd</u>		<b>3. (b) Social Security Number</b> _____	
<b>4. Sex</b> <u>Male</u> <b>5. Color or race</b> <u>Negro</u> <b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u> <b>6. (b) Name of husband or wife</b> <u>Loris Byrd</u> <b>6. (c) If alive, give age</b> _____ years <b>7. Birth date of deceased (mo., day, yr.)</b> <u>July 22 - 1905</u> <b>8. AGE:</b> Years <u>41</u> Months <u>1</u> Days <u>15</u> If less than one day _____ hrs. _____ min.		<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>Sept 7</u> 19 <u>46</u> at _____ M <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>7-10-46</u> to <u>9-7-46</u> and that I last saw him alive on <u>9-7-46</u> <b>Immediate cause of death</b> <u>Acute myocarditis</u> <b>Due to</b> <u>Acute Pneumonia</u> <b>Other conditions</b> <u>Acute Pleuritis</u> (Include pregnancy within 3 months of death) <b>Major findings of operations</b> _____ _____ Date of op. _____ <b>Autopsy results</b> _____ <b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.	
<b>9. Birthplace</b> <u>Norristown South Carolina</u> (Town, county, and state) <b>10. Usual occupation</b> <u>Distillery Mechanic</u> <b>11. Industry or business</b> _____		<b>DURATION</b> <u>9-7-46</u> <u>7-18-46</u> <u>7-10-46</u>	
<b>12. Name</b> <u>Ben Byrd</u> <b>13. Birthplace</b> <u>Newking Co. S. C.</u> <b>14. Maiden name</b> <u>Margaret Ingram</u> <b>15. Birthplace</b> <u>Lawrence Co. S. C.</u>		<b>16. Informant</b> <u>Mr. Loris Byrd (wife)</u> Address <u>519 S. Stokes</u>	
<b>17. Burial</b> <u>Beaumont</u> (Burial, cremation, or removal. Which?) _____ Date thereof <u>9/12/46</u> (month) (day) (year) Cemetery or crematory _____ <u>Lawrence Co. S. C.</u> Location _____ <u>Penningson &amp; Row</u> <b>18. Funeral director</b> _____ Address <u>Harrods Creek Md.</u>		<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____	
<b>19. Date rec'd by registrar</b> <u>Sept. 8</u> 19 <u>46</u> <u>G. H. Lewis m.d.</u> Registrar		<b>23. SIGNATURE</b> <u>Charles L. Lowan m.d.</u> M. D. or other _____ Address <u>Harrods Creek</u> Date signed <u>9-8-46</u>	

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SEP 10 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-4

## CERTIFICATE OF DEATH

Reg. Dist. No. 09053 125

<b>1. PLACE OF DEATH:</b> County <u>Harpard</u> City or town <u>Harford</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>3 days</u> Hospital, institution, or street address where death occurred: <u>Harford Memorial Hospital</u> How long in hospital or institution? <u>3 days</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Harford</u> City or town <u>Aberdeen</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Bush Chapel Rd #1</u> (If rural, give LOCATION) 2.(a) If veteran, name war _____			
<b>3. (a) FULL NAME</b> <u>Joseph B. Carlisle</u>				<b>3. (b) Social Security Number</b> _____			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6.(a) Single, married, widowed, or divorced</b> <u>Married</u>		<b>MEDICAL CERTIFICATION</b>	
<b>6.(b) Name of husband or wife</b> <u>Eliz. D. Carlisle</u>				<b>20. DATE OF DEATH</b> <u>Sept. 6</u> 19 <u>46</u> at <u>10:30 P</u>			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>April 30, 1891</u>				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Sept. 3</u> 19 <u>46</u> <b>to</b> <u>Sept. 6</u> 19 <u>46</u>			
<b>8. AGE:</b> Years <u>75</u> Months <u>5</u> Days <u>6</u> If less than one day _____ hrs. _____ min.				<b>and that I last saw him alive on</b> <u>Sept 6</u> 19 <u>46</u>			
<b>9. Birthplace</b> <u>Maryland</u> (Town, county, and state)				<b>Immediate cause of death</b> <u>Cardio-Vascular Collapse</u>			
<b>10. Usual occupation</b> <u>Farmer</u>				<b>Due to</b> <u>Hemorrhage</u>			
<b>11. Industry or business</b> <u>Retired</u>				<b>Due to</b> <u>Cancer of prostate</u>			
<b>12. Name</b> <u>William Carlisle</u>				<b>Other conditions</b> _____			
<b>13. Birthplace</b> <u>Del.</u>				(Include pregnancy within 3 months of death)			
<b>14. Maiden name</b> <u>Sara Peterson</u>				<b>Major findings of operations</b> _____			
<b>15. Birthplace</b> <u>Md.</u>				Date of op. _____			
<b>16. Informant</b> <u>Elizabeth D. Carlisle</u>				<b>Autopsy results</b> _____			
Address <u>Aberdeen Maryland #1</u>				<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>17. Burial</b> <u>Burial</u> Date thereof <u>Sept. 9, 1946</u> (Burial, cremation, or removal. Which) (month) (day) (year)				<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>			
Cemetery or crematory <u>St. Zion</u>				Accident, suicide, or homicide _____ Date of _____			
Location <u>Harford Co. Md.</u>				Where did injury occur? _____ (City or town) _____ (County) _____ (State)			
<b>18. Funeral director</b> <u>R. Madison Mitchell</u>				Injured at home, farm, industry, public place (where?) _____			
Address <u>Harford Md.</u>				Means of injury _____ Injured at work? _____			
<b>19. 9-9</b> 19 <u>46</u> <u>R. D. Lewis M.D.</u> (Date rec'd by registrar) Registrar				<b>23. SIGNATURE</b> <u>Dudley Sullivan MD</u> <u>Harford Memorial Hosp</u> M.D. or other _____ Address _____ Date signed <u>9/6/46</u>			

MINISTRY OF DEFENSE

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SEP 10 1946

EAU V.E.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (836)

## CERTIFICATE OF DEATH

09054 185-  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County HarfordCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs.

Hospital, institution or street address where death occurred:

St. Francis VillaHow long in hospital or institution? 6 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)Street No. Commerce & Market  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sister Mary Phantilla (Catherine Casey)

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

August 15 - 1877

6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

6910

hrs.

min.

## 9. Birthplace

Ireland

(Town, county, and state)

## 10. Usual occupation

Nurse

## 11. Industry or business

FATHER

## 12. Name

Charles Casey

## 13. Birthplace

Ireland

MOTHER

## 14. Maiden name

Mary Shields

## 15. Birthplace

Ireland

## 16. Informant

Hot Records

## Address

Harford

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 9/18/46

(month) (day) (year)

## Cemetery or crematory

Holy Redeemer

## Location

Baltimore, Md.

## 18. Funeral director

Permyington & Son

## Address

Harford

## 19.

(Date rec'd by registrar)

19 46G. L. Lewis

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 19 46, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 19 47, to Sept 15 19 46and that I last saw him alive on Sept 15 19 46

Immediate cause of death

Arterio SclerosisHypertension

Due to

Myocardial Infarction

Due to

Other conditions

Typhoid

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles J. Foley

M.D. or other

Address

Harford

Date signed

9/17/46

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09055

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County HarfordCity or town Mountain Green  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Roberta Coomes

## 3. (b) Social Security Number

No4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced married6. (b) Name of husband Mitchel Coomes6. (c) If alive, give age alive years7. Birth date of deceased (mo., day, yr.) March 13, 18668. AGE: Years 80 Months 5 Days 28 If less than one day

.....hrs. ....min.

9. Birthplace Alleghany Co. N.C.

(town, county, and state)

10. Usual occupation housework11. Industry or business at home12. Name Richard C. Coomes13. Birthplace Alleghany Co. N.C.14. Maiden name Martha Jennings15. Birthplace Alleghany Co. N.C.16. Informant Mr. Mitchel CoomesAddress Bel - Air, Md. RuralBurial17. (Burial, cremation, or removal, which?) Date thereof Sept 14, 1946

(month) (day) (year)

Cemetery or crematory Oak Grove Cem.Location Harford Co. Md.18. Funeral director H. B. BaileyAddress Charlottesville, Md.19. Sept. 13, 1946 M. G. Kirsle

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Rural Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No. Mountain Green

(If rural, give LOCATION)

2. (a) If veteran, name war No

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11, 1946 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 7, 1946 to Sept 11, 1946and that I last saw her alive on Sept 11, 1946Immediate cause of death Coronary ThrombosisDURATION 4 da

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P. HudsonAddress Forest Hill, Md Date signed 9/13/46

M. D. or other

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BUREAU V E

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Evidence for exchange of

## MARYLAND STATE DEPARTMENT OF HEALTH

birth date of deceased is shown

2411 N. Charles St., Baltimore 472 ✓

09056

FILM No. I 07 OCT 8 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 186-

## 1. PLACE OF DEATH:

County Harford  
 City or town Have de Grace Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 wks.  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
 How long in hospital or institution? 3 wks.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Bel Air Rd 2  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. at Harford Furnace Md.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mattie Maslette Cullum.

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Rudolph Cullum  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 4, 1884 November 26, 1888  
 8. AGE: Years 57 Months 2 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore city Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name William Ball

13. Birthplace Baltimore Co. Md.

14. Maiden name Mary Liona Russell

15. Birthplace Baltimore city Md.

16. Informant Myron S. Foote

Address Bel Air Md.

17. Burial Date thereof Sept 6, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bakers Cemetery

Location near Aberdeen Md.

18. Funeral director Tanning & Sons

Address Aberdeen Md.

19. Sept-5- 1946 G. L. Lewis M. D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept 2, 1946 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1, 1946 to Sept 2, 1946

and that I last saw him alive on Sept 2, 1946

Immediate cause of death \_\_\_\_\_

Carcinoma of

right lung

Due to Secondary Carcinoma

Due to toxin

Other conditions Dachryia

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. Charles J. Foley M.D.

M. D. or other \_\_\_\_\_

Address Harford Md. Date signed Sept 9/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THIS COPY IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 195

<b>1. PLACE OF DEATH:</b> County <u>Harford</u> City or town <u>Navre de Grace</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Life</u> Hospital, institution, or street address where death occurred: <u>617 So. Washington St.</u> How long in hospital or institution? _____				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Md.</u> County <u>Harford</u> City or town <u>Navre de Grace</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>617 So. Washington St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war _____			
<b>3. (a) FULL NAME</b> <u>Willard Hammond Day</u>				<b>3. (b) Social Security Number</b> <u>217-16-1553</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>Blanche P. Day</u>				<b>6. (c) If alive, give age</b> <u>52</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Aug. 17, 1893</u>				<b>8. AGE:</b> Years <u>53</u> Months <u>1</u> Days <u>0</u> If less than one day _____ hrs. _____ min.			
<b>9. Birthplace</b> <u>Navre de Grace Md.</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Asst. Cashier</u>			
<b>11. Industry or business</b> <u>First Natl. Bank Bldg.</u>				<b>12. Name</b> <u>Wm F. Day</u>			
<b>13. Birthplace</b> <u>Md.</u>				<b>14. Maiden name</b> <u>Mary Hammond</u>			
<b>15. Birthplace</b> <u>Md.</u>				<b>16. Informant</b> <u>Mrs. Blanche P. Day</u> Address <u>617 So. Washington St. City.</u>			
<b>17. Burial</b> <u>Sept. 20, 1946</u> (Burial, cremation, or removal, Which?) _____ Cemetery or crematory <u>Wheat Hill</u> Location <u>Navre de Grace, Md.</u> <b>18. Funeral director</b> <u>R. Madison Mitchell</u> Address <u>Navre de Grace, Md.</u>				<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____			
<b>19. (Date rec'd by registrar)</b> <u>Sept. 19, 1946</u>				<b>23. SIGNATURE</b> <u>Charles J. Felt</u> M. D. or other _____ Address _____ Date signed <u>9/19/46</u>			

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1946 at 7:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to Sept. 17, 1946 and that I last saw him alive on Sept. 17, 1946

Immediate cause of death Arterio Sclerosis  
Coronary Thrombosis  
 Due to Hypertension  
 Due to \_\_\_\_\_  
 Other conditions Cardiac Failure  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

RECEIVED  
SEP 21 1945  
RTRFAU 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195-d

## CERTIFICATE OF DEATH

09058

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Hartford  
 City or town Forest Hill (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Hartford  
 City or town Forest Hill (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.

## 3. (a) FULL NAME

GERALDINE ELLIS

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S  
 6. (b) Name of husband or wife ✓  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) SEPT 4 / 1946  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Forest Hill, Md  
 (Town, county and state)  
 10. Usual occupation ✓  
 11. Industry or business ✓  
 12. Name Sam Hoya Ellis  
 13. Birthplace N.C.  
 14. Maiden name Edna Church  
 15. Birthplace N.C.

16. Informant Mrs Edna C Ellis  
 Address Forest Hill, Md  
 17. Burial Date thereof Sept 19 / 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Sharon Baptist C.  
 Location Sharon, Md Rural

18. Funeral director Dean & Sister  
 Address Bel Air, Md

19. 9/19 46 Pineville, Pa  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 18 19 46 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death ASPHYXIA DURATION  
 Due to PROBABLY DUE TO  
ASPIRATION OF FEEDING  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE J. H. Ramsey M.D.  
Dep. Medical Examiner  
 Address Aberdeen, Md Date signed 9/18/46

RECEIVED  
SEP 21 1946  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County... Hartford  
 City or town... EMMORTON  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 23 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... MD County... Hartford  
 City or town... EMMORTON RURAL  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

James H Ely

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

m w

6. (b) Name of husband or wife... Sarah Y Bond

7. Birth date of deceased (mo., day, yr.) Jan 17 - 1864 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
829. Birthplace... Hartford Co., Md  
(Town, county, and state)10. Usual occupation... Farmer

## 11. Industry or business

12. Name... John Ely13. Birthplace... MD14. Maiden name... Hannah Tucker15. Birthplace... MD16. Informant... Mrs Nellie MorlockAddress... Bel Air Md, RD 217. Burial... Date thereof... Sept 18/1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Calvary, MethodistLocation... Hartford Co., Md.18. Funeral director... Dean & SonAddress... Bel Air Md19. 9/18 46 Priscilla Lowndes  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept 16 1946 at 11:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-7 1944 to 9-16 1946and that I last saw him alive on Sept 15 1946Immediate cause of death... coronary occlusion DURATION 2 wksDue to... arterial sclerosis 10 yrs

myocarditis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE... Fred O Hodous M. D. or otherAddress... Edgewood Md Date signed... 9-16-46

RECEIVED  
SEP 21 1946  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

## CERTIFICATE OF DEATH

09060

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Harford  
 City or town Forest Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 days  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Baltimore  
 City or town City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2907 Hildrise Drive  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Pauline A. Grafton

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 4 1891

8. AGE: Years 55 Months 8 Days 21 If less than one day hrs. min.

9. Birthplace Forest Hill Harford co md (Town, county, and state)

10. Usual occupation P.B.X. Operator

11. Industry or business Sales Lady

12. Name A. Duran Grafton

13. Birthplace Forest Hill md

14. Maiden name Elizabeth Kean

15. Birthplace Forest Hill md

16. Informant Mr. Fred R. Tucker

Address Forest Hill md.

17. Burial (Burial, cremation, or removal) Which? Date thereof Sept 27 46 (month) (day) (year)

Cemetery or crematory Rock Spring

Location Forest Hill md

18. Funeral director Martin Knuff

Address Jamtownville md.

19. 9/26 46 Priscilla Lowwood

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1946 at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 16 1946 to Sept. 25 1946

and that I last saw him alive on September 24 1946

Immediate cause of death Broncho Pneumonia

DURATION

1 day

Due to Cerebral Embolism 3 months

Due to Auricular Fibrillation about 20 years

due to probably rheumatic fever unknown

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Barth MD

M. D. or other

Address Forest Hill, Maryland Date signed 9/25/46

ARTESIAN LEDGER

SAC CONTENT

RECEIVED

SEP 28 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09061

Reg. Dist. No.

1985

## 1. PLACE OF DEATH:

County... *Harford*City or town... *Harrode Grace*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *12 yrs*

Hospital, institution, or street address where death occurred:

*Ontario St. Extended*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Md.* County... *Harford*City or town... *Harrode Grace*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *Ontario St. Extended*  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

*Martha Elizabeth Heuse*

## 3. (b) Social Security Number

## 4. Sex

*Female*

## 5. Color or race

*White*

## 6. (a) Single, married, widowed, or divorced

*Widowed*

## 6. (b) Name of husband or wife

*F. Clifton Heuse*

6. (c) If alive, give age... years

## 7. Birth date of

deceased (mo., day, yr.)

## 8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

## 8. Birthplace

*Baldw. Md.*  
(Town, county, and state)

## 10. Usual occupation

*Housewife*

## 11. Industry or business

*John Gline*

## 12. Name

*John Gline*

## 13. Birthplace

*Penn.*

## 14. Maiden name

*Rachel P. Gribble*

## 15. Birthplace

*Md.*

## 16. Informant

*Mrs. A. N. Thompson*

## Address

*Ontario St. Ext. City*

## 17. Burial

*Burial*

## (Burial, cremation, or removal. Which?)

*Sept 27 1946*

## Date thereof

*Sept 27 1946*

## (month) (day) (year)

## Cemetery or crematory

*Angel Hill*

## Location

*Harrode Grace, Md.*

## 18. Funeral director

*R. Madison Mitchers*

## Address

*Harrode Grace, Md.*

## 19. Date rec'd by registrar

*Sept 27 1946*

## Registrar

*G. L. Lewis*

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*Sept. 24 1946 at 1:00 P.M.*

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*June 7 1946 to Sept 24 1946*and that I last saw him alive on *Sept 24 1946*

## Immediate cause of death

*Arteriosclerosis**Hypertension**Coronary Atherosclerosis**Myocardial Infarction**Chronic Kidney Disease**Chronic Liver Disease**Chronic Lung Disease**Chronic Stomach Disease**Chronic Intestine Disease**Chronic Urinary Disease**Chronic Nervous System Disease**Chronic Skin Disease**Chronic Bone Disease**Chronic Blood Disease**Chronic Endocrine Disease**Chronic Reproductive System Disease**Chronic Sensory Organ Disease**Chronic Musculoskeletal Disease**Chronic Immune System Disease**Chronic Connective Tissue Disease**Chronic Metabolic Disease**Chronic Nutritional Disease**Chronic Environmental Disease**Chronic Infectious Disease**Chronic Parasitic Disease**Chronic Neoplastic Disease**Chronic Degenerative Disease*

## 22. VIOLENCE: If death was due to external causes, fill in the following:

*Accident, suicide, or homicide*

## Where did injury occur?

*(City or town) (County) (State)*

## Injured at home, farm, industry, public place (where?)

*(City or town) (County) (State)*

## Means of injury

*Injured at work?*

## 23. SIGNATURE

*Charles J. Foley*

## Address

*Harrode Grace, Md.*

## Date signed

*Sept 27 1946*

RECEIVED

SEP 30 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

• THIS CERTIFICATE LIMITED TO 99

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 148-2

## CERTIFICATE OF DEATH

09062



Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County Harford  
 City or town Harford  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Cecil  
 City or town Rural. Liberty Grove  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Amy Howell

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M  
 6.(b) Name of husband or wife Levi L. Howell  
 8.(c) If alive, give age 28 years  
 7. Birth date of deceased (mo., day, yr.) Mar. 15, 1915  
 8. AGE: Years 31 Months 5 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Kentucky  
 (Town, county, and state)  
 10. Usual occupation Homemaker  
 11. Industry or business Home  
 12. Name Harland J. Howell  
 13. Birthplace Kentucky  
 14. Maiden name Emily Robinson  
 15. Birthplace Kentucky

16. Informant Levi L. Howell  
 Address Liberty Grove, Cecil Co., Md.  
Removal  
 17. (Burial, cremation, or removal) Which? Sept. 7, 1946  
 Date thereof \_\_\_\_\_ (month) \_\_\_\_\_ (day) \_\_\_\_\_ (year)  
 Cemetery or crematorium Pike Co. Bur.  
 Location Pike Co., Kentucky  
 18. Funeral director J. Madison Mitchell  
 Address Harford, Md.  
 19. Sept. 5 - 1946 G. L. Lewis Jr.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 19 46 at 3:40 p.  
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 4 19 46 to Sept 4 19 46  
 and that I last saw him alive on Sept 4 19 46  
 Immediate cause of death Eclampsia  
Pregnancy  
delivered  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

## DURATION

11 hr.

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where)? \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Dwight Shelton MD  
Harford Mem. Hosp. M.D. or other \_\_\_\_\_  
 Date signed 9/4/46

RECEIVED

SEP 7 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09063

Reg. Dist. No. 185-

## 1. PLACE OF DEATH

County Harford  
 City or town Hane de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 85 yrs. 10 mo. 17 days  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town Hane de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 524 N. Washington  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Lillian De Moss Kennedy

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Geo. H. Kennedy (dec.)

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) 10/19/1860

8. AGE: Years 85 Months 10 Days 17 If less than one day  
 hrs. min.

8. Birthplace Hane de Grace  
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name Dennis Malone13. Birthplace Pennsylvania14. Maiden name Anne Reese15. Birthplace Pennsylvania16. Informant Mr. William FosterAddress 524 N. Washington17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 9/9/46  
(month) (day) (year)Cemetery or crematory Angel HillLocation Hane de GraceFuneral director Pennington & CoAddress Hane de Grace

19. Sept: 8 46 A. L. Lewis M.D. Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6 1946, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 4 1942, to 9-6 1946  
 and that I last saw him alive on 9-6 1946

Immediate cause of death Cardiac Insufficiency

DURATION

Due to Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE A. L. Lewis M.D.Address Hane de Grace MdDate signed 9-8-46

M. D. or other

RECEIVED

SEP 10 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

## CERTIFICATE OF DEATH

Reg. Dist. No. 090682

## 1. PLACE OF DEATH:

County Harford  
 City or town Bel Air (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 months  
 Hospital, institution, or street address where death occurred:  
Harford Convalescent Home  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford  
 City or town Rural - Bel Air  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Harford Convalescent Home  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

Martha Ann Kirkwood  
 4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife James R. H. Kirkwood  
 6. (c) If alive, give age 78 years  
 7. Birth date of deceased (mo., day, yr.) Oct 12, 1868  
 8. AGE: Years 77 Months 10 Days 27 If less than one day  
 hrs. min.

9. Birthplace Harford County, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife

11. Industry or business  
 12. Name John McComas  
 13. Birthplace Harford County  
 14. Maiden name Mary Long  
 15. Birthplace Harford County

16. Informant Mr. Bushrod R. Hatto  
 Address 100 Yorklight Rd. Towson  
 17. Burial Sept 12, 46  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Bethel  
 Location Madonna Harford County, Md.  
 18. Funeral director Martin G. Hunt  
 Address Jarrettsville, Md.

19. 9/10 46 Priscilla Lowwood  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1946 at 4:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1946 to Sept 9 1946  
 and that I last saw alive on Sept 9 1946  
 Immediate cause of death Chr. Myocardial Disease DURATION 3  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other  
Frost Hill, Md. Date signed 9/9/46  
 Address

RECEIVED  
SEP 13 1946  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09065

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex.....

5. Color of race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal of remains)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

19. 46 M. H. Kirk

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him/her alive on.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

DURATION

2 yrs

RECEIVED

SEP 21 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:  
 County Norfolk  
 City or town Hamstead Shore  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hosp  
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Md. County Cecil C.  
 City or town Port Deposit Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Leona La Rue

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Coloured 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Monis Lane  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) March 2 1893  
 8. AGE: Years 53 Months 6 Days 18 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Port Deposit Md.  
 (Town, county, and state)

10. Usual occupation Janitor

11. Industry or business \_\_\_\_\_

12. Name William McMullen

13. Birthplace Perryville Md.

14. Maiden name Clara Waifield

15. Birthplace Port Deposit Md.

16. Informant Clara McMullen

Address Port Deposit Md.

17. Burial Date thereof Sept 22 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cokesbury

Location Port Deposit Md.

18. Funeral director E. T. Tupper

Address 12345 Sun Rd.

19. Sept. 20 1946 A. L. Lewis M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1946 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-18 1946, to 9-19 1946.

and that I last saw him/her alive on 9-19 1946.

Immediate cause of death Cerebral Vascular Accident DURATION 45 min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. M. D. M. D. or other \_\_\_\_\_

Address Port Deposit Md. Date signed 9-20-46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
SEP 23 1946  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the name is shown on

G108 12/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford

City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John W. Lynch

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife

Pheresa Lynch

7. Birth date of deceased (mo., day, yr.)

Sept 3, 1861

8. (c) If alive, give age years

85

8. AGE

85

2

hrs.

min.

9. Birthplace

Ind.

Retired Farmer

10. Usual occupation

Retired Farmer

11. Industry or business

Retired Farmer

12. Name

Reynis Wapital

13. Birthplace

Ireland

14. Maiden name

Julia Wapital

15. Birthplace

Ireland

16. Informant

Wm. Paul Wapital

Address

Fallston

17. Burial

Burial

Date thereof

9/9/46

(month) (day) (year)

Cemetery or crematory

St. Johns

Location

Long Green Rd

18. Funeral director

Hamberger Bros

Address

Benson Md.

19. 9/6

46

Priscilla Lowood

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Lincoln

City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 100  
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

LYNCH

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1946 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946 to September 6 1946

and that I last saw him alive on Sept 3 1946

Immediate cause of death uraemic coma

two days

Due to: Urinary suppression - kidney dysfunction

Severity

48 hours

Due to Anterior scleritis

Other conditions arterial sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

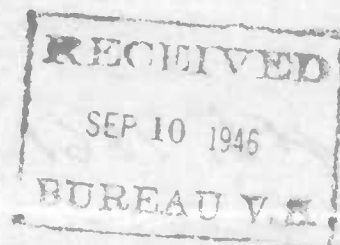
23. SIGNATURE W. M. Stirling M.D.

M. D. or other

Address Fallston Md.

Date signed 9/6/46

8  
1981  
946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-2

## CERTIFICATE OF DEATH

09067

Reg. Dist. No. 183-

## 1. PLACE OF DEATH:

County HarfordCity or town Harreds Grace  
(if outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 mo.

Hospital, institution, or street address where death occurred:

811 N. Adams, St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Harreds Grace  
(if outside city or town limits, write RURAL and give nearest town)Street No. 811 N. Adams, St.  
(if rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Mary Monk

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Black 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Isaac Monk7. Birth date of deceased (mo., day, yr.) Apr. 26, 1881 8. (c) If alive, give age - years8. AGE: Years 65 Months 4 Days 27 If less than one day - hrs. - min.9. Birthplace Harford Co. Md.  
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business

12. Name Geo. Cox13. Birthplace Md.14. Maiden name Mary Fancea Cox15. Birthplace Md.16. Informant Mrs. Estella DysonAddress 811 N. Adams, St. City.17. Burial Burial Date thereof Sept 25, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Saran CreekLocation Harford Co.18. Funeral director R. Madison MitchellAddress Harreds Grace, Md.19. Sept. 25 - 1946

(Date rec'd by registrar)

G. L. Lewis m.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1946 at 5:24 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1, 1946 to Sept. 23, 1946 and that I last saw her alive on Sept. 22, 1946

Immediate cause of death

Chronic Parenchymatous Degeneration 8-1-46

Due to

Arteriosclerosis 1945-

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Claude L. Cowan m.d.  
M. D. or other Harreds Grace Date signed 9-24-46

RECEIVED  
SEP 27 1945  
BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 172

09068

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

**1. PLACE OF DEATH:**  
County Harford  
City or town Aberdeen Proving Ground, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 1/2 years  
Hospital, institution, or street address where death occurred:  
Station Hospital, Aberdeen Proving Ground, Maryland  
How long in hospital or institution? 2 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)  
State Maryland County Harford  
City or town Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 130 Rogers Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

**3. (a) FULL NAME**  
Captain Andrew B. C. Nicholls, O-910 850

**3. (b) Social Security Number**

**4. Sex** Male **5. Color or race** White **6. (a) Single, married, widowed, or divorced** Married

**6. (b) Name of spouse** Marjorie (Wife)

**7. Birth date of deceased (mo., day, yr.)** 26 August 1910 **8. (c) If alive, give age** \_\_\_\_\_ years

**8. AGE:** Years 36 Months 0 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

**9. Birthplace** Tuscaloosa, Alabama  
(Town, county, and state)

**10. Usual occupation** Officer - U. S. Army

**11. Industry or business**

**12. Name** George J. Nicholls

**13. Birthplace** Foster, Alabama

**14. Maiden name** Ellen J. Smith Nicholls

**15. Birthplace** Mobile, Alabama

**16. Informant** Mrs. Marjorie Nicholls (Wife)

**Address** 130 Rogers St., Aberdeen, Md.

**17. Transportation** Sept. 9, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

**Cemetery or crematory** Jones & Spigner Funeral Home

**Location** Tuscaloosa Ala.

**18. Funeral director** Howard K. McComas & Son

**Address** Abingdon Md.

**19. Date rec'd by registrar** Sept 12 1946 Nellie H. Riley  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

**20. DATE OF DEATH** 7 September 1946 at 2 A M

**21. I CERTIFY** that death occurred on the date above stated; that I attended deceased from 4 September 1946 to 7 September 1946

and that I last saw him alive on 7 September 1946

**Immediate cause of death** Peritonitis

**DURATION**  
20 hours

**Due to** Perforated Posterior Duodenal Ulcer  
20 hours

**Due to** Chronic Posterior Duodenal Ulcer  
4 Years

**Other conditions** None

(Include pregnancy within 3 months of death)

**Major findings of operations** None

**Autopsy results** Peritonitis & Perf. Duodenal Ulcer  
**PHYSICIAN:** Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

**23. SIGNATURE** Sidney Brenner  
SIDNEY BRENNER, Capt., MC D. or other

Address \_\_\_\_\_ Date signed \_\_\_\_\_

I Certify that I have received the remains of the above in good condition.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 16 1946  
BUREAU A B

6812

2.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09069

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County HanfordCity or town near Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

near Bush Chapel Road - RFD #1

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HanfordCity or town near Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bush Chapel

(If rural, give LOCATION)

2.(a) If veteran, name war none

## 3. (a) FULL NAME

JOSEPH RAYMOND OSBORNE

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

Sept. 19th 1945

## 8. AGE:

Years

Months

Days

If less than one day

17

\_\_\_\_\_ hrs.

\_\_\_\_\_ min.

9. Birthplace near Aberdeen Hanford Co., Md.

(Town, county, and state)

10. Usual occupation none

## 11. Industry or business

none

## MOTHER

## FATHER

## 12. Name

Ernest Butler

## 13. Birthplace

Unknown

## 14. Maiden name

Mabel Osborne

## 15. Birthplace

Aberdeen

## 16. Informant

Address

Mabel OsborneAberdeen, Md. R.D.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 28 1946

Cemetery or crematory

Mt Calvary

Location

near Aberdeen

## 18. Funeral director

Address

Henry TarringtonAberdeen, Md.

## 19.

(Date rec'd by registrar)

19

46Nellie Z. Riley

Registrar

## MEDICAL CERTIFICATION

Approx20. DATE OF DEATH SEPT 26, 1946, at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

TOXEMIA due to  
Intestinal obstruction

DURATION

Due to

Due to

Other conditions

Malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op. \_\_\_\_\_

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

J. H. Ramsey, M.D.  
Dep. Medical ExaminerAddress Aberdeen, Md. Date signed 9/26/46

RECEIVED

OCT 1 1946

BUREAU V F

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County HarfordCity or town Harlington Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Harlington Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war ms

## 3. (a) FULL NAME

James P. Patrick

## 3. (b) Social Security Number

no

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widower

## 6. (b) Name of husband or wife

Cladomy Patrick7. Birth date of deceased (mo., day, yr.) Sept. 13 18648. AGE: 82 Years 0 Months 16 Days hrs. min.9. Birthplace Russell Co., Va.

(Town, county, and state)

10. Usual occupation Farmer11. Industry or business Crop Farmer12. Name Herakias Patrick13. Birthplace Smith Co., Va.14. Maiden name Rachel Harrison15. Birthplace Smith Co., Va.16. Informant Mr. Lonnie PatrickAddress Harlington Md. R.D.17. Burial Oct 2 1946

## (Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Mt. Zion Cem.Location Harford Co., Md.18. Funeral director H. S. BaileyAddress Harlington Md.19. Sept 30 1946 M. C. Kirk

## (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1946 at 8:30 M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1946 to Sept 29 1946and that I last saw him alive on Sept 28 1946Immediate cause of death Cerebral Hemorrhage DURATION 1 hr.Due to Cerebral Sclerosis 2 yrsDue to hypertensionOther conditions Myocarditis

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE F. P. Smith M. D. SmithAddress Harlington Md. Date signed 9/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 9 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

Reg. Dist. No. 09071 185

## 1. PLACE OF DEATH:

County Hagerford  
 City or town Dave de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 days  
 Hospital, institution, or street address where death occurred:  
Hagerford Memorial Hospital  
 How long in hospital or institution? 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford  
 City or town Dave de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 100  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW II

## 3. (a) FULL NAME

Petaccio, Sharon Elizabeth

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) August 22, 1946 6.(c) If alive, give age 19 years

8. AGE: Years 19 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Dave de Grace, Md.  
 (Town, county, and state)

10. Usual occupation Infant11. Industry or business None12. Name Louis P. Petaccio13. Birthplace Ohio14. Maiden name Marion B. Rollins15. Birthplace Magnolia Md16. Informant Louis P. PetaccioAddress Magnolia Md

17. Burial Date thereof Sept 11 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CokeburyLocation Abingdon Maryland18. Funeral director Howard W. McNameeAddress Abingdon Maryland19. Sept 11 1946 G. L. Lewis Jr.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 19 46 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 19 46 to Sept 10 19 46  
 and that I last saw him alive on Sept 9 19 46

Immediate cause of death PrematurityDURATION 19 dayDue to PrematurityDue to PrematurityOther conditions None

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE Daddy Phillip M.Address Harford Memorial Hosp signed 9/10/46

RECEIVED  
SEP 12 1948  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County HarfordCity or town Waverle Grace  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Perryville Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Pamela Infant. Pinto

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

9-1-46

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

3

hrs. min.

9. Birthplace Waverle Grace Harford Co., Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

George J. Pinto

## 13. Birthplace

Salisbury, Md.

## MOTHER

## 14. Maiden name

Rebecca Patterson

## 15. Birthplace

Perryville Md.

## 16. Informant

Berton B. Patterson

## Address

Perryville, Md.

## 17.

(Burial, cremation, or removal. Which)

Date thereof Sept 3, 1946  
(month) (day) (year)

## Cemetery or crematory

Asbury

## Location

Port Deposit Md. Rural

## 18. Funeral director

Lee A. Patterson & Son

## Address

Perryville, Md.

## 19.

(Date rec'd by registrar)

Sept 3 1946D. F. Lewis, Jr.

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

9-3-46 at 12:30 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 1946 to Sept 3 1946  
and that I last saw him alive on Sept 3 1946

## Immediate cause of death

Pre-mature  
7 months

## DURATION

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Port Deposit Md. Date signed 9-3-46

RECEIVED

SEP 5 1946

BUREAU V A

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Ba*

## CERTIFICATE OF DEATH

Reg. Dist. No. *0907381*

## 1. PLACE OF DEATH:

County *Harford County*City or town *Abertdeen*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *74 years*Hospital, institution, or street address where death occurred  
*Death occurred at home*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Harford*City or town *Burial Aberdeen*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *Short Lane*  
(If rural, give LOCATION)2.(a) If veteran, name war *none*

## 3. (a) FULL NAME

*Mrs Ella Pitt*

## 3. (b) Social Security Number

*none*4. Sex *female* 5. Color or race *colored* 6. (a) Single, married, widowed, or divorced *widowed*

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *April 1 1872* 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years *74* Months *5* Days *4* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace *Harford County, Md*  
(Town, county, and state)10. Usual occupation *none*11. Industry or business *none*12. Name *Trilux Whymms*13. Birthplace *Harford Co. Md*

14. Maiden name

15. Birthplace

16. Informant *Blanche Tilden*Address *45 Hampden St Aberdeen Md*17. *Burial* Date thereof *Sept 9 1946*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *cemetery Union ME.*Location *Swann Creek Church*18. Funeral director *John H. Terring*Address *Aberdeen Md*19. *Sept 9* 19*46* *Nellie H. Riley*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 7* 19*46* at *4* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *August 29 1946* to *Sept 7 1946* and that I last saw him alive on *Sept 7 1946*

Immediate cause of death

*Pulmonary Edema* DURATION *1 day*Due to *myocardial failure* *2 day*Due to *cerebral hemorrhage & hemiplegia (left)* *10 day*Other conditions *arteriosclerosis*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Louise Unbehauen* M. D. or otherAddress *Harford Md* Date signed *Sept 9*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

RECEIVED

SEP 16 1946

BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 946

## CERTIFICATE OF DEATH

Reg. Dist. No. 090741 82

### 1. PLACE OF DEATH:

County Hartford  
City or town Hartford Shop  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 34 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Hartford  
City or town Hartford Shop  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Maybell Tawney Price

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife George E Price

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26 - 1875

8. AGE: Years 70 Months 9 Days 25 If less than one day  
.....hrs. ....min.

9. Birthplace Poring, Balto. Co., Md  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Andrew C Tawney

13. Birthplace Md

14. Maiden name Agnes Taylor

15. Birthplace Md

16. Informant George E Price

Address Forest Hill, Md

17. Burial Date thereof Sept 27 / 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bell Air Burial Park

Location Bell Air, Md

18. Funeral director Dean Y. Foster

Address Bell Air, Md

19. 9/23 46 Priscilla Lowwood  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1946 at 4:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Sept 21 1946 and that I last saw her alive on Sept 21 1946

Immediate cause of death Cerebral Paresis DURATION 7 days

Due to ✓

Due to ✓

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. P. Prograss M. D. or other  
Address Darlington Md Date signed 9/22/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECU

SEP 28 1946

BUREAU 7 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09075

Reg. Dist. No.

182

## 1. PLACE OF DEATH:

County Harford  
 City or town Harlingston Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 72 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford  
 City or town Harlingston Rural  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Amanda A Randow

## 3. (b) Social Security Number

NO

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife James L Randow

Head 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 9, 1874

8. AGE: Years 72 Months 2 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Harford Co., Md.  
 (Town, county, and state)

10. Usual occupation Housework11. Industry or business at home12. Name Edward Rhoades13. Birthplace York Co., Penna.14. Maiden name Unknown

15. Birthplace

16. Informant Mr. Elmer RandowAddress Harlingston, Md.17. Burial Date thereof Sept. 15, 1946

(Burial, cremation, or removal, etc.) (month) (day) (year)

Cemetery or crematory Reubens' Cem.Location Harford Co., Md.18. Funeral director H. S. BaileyAddress Harlingston, Md.19. Sept. 13, 1946 Registrar M. W. Hirsch

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1946, at 11:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20, 1946, to Sept. 12, 1946, and that I last saw him alive on Sept. 12, 1946.

Immediate cause of death Cerebral embolus DURATION 3 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE NE. Gallion M. D. or otherAddress Harlingston, Md. Date signed 9-14-46

RECEIVED  
SEP 21 1946  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Harford  
 City or town Forest Hill md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford  
 City or town Forest Hill md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ellis Truman Reynolds

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Bertie Deese  
 8. AGE: Years 60 Months 7 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 7. Birth date of deceased (mo., day, yr.) Feb 10 1886 8. (c) If alive, give age 78 years

9. Birthplace Chome Hill Harford Co md  
 (Town, county, and state)

10. Usual occupation millers

11. Industry or business Retired

12. Name Harmora Ora Reynolds

13. Birthplace Lancaster Co Pa

14. Maiden name Mary Emma Truman

15. Birthplace Cecil Co md

16. Informant Mrs Ellis Reynolds

Address Forest Hill md

17. Burial Date thereof Sept 29 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wm Watus Memorial

Location Cool town Harford Co md

18. Funeral director Martha Blunt

Address Jarrettsville md

19. 9/28 1946 Pincilla Lowndes  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1946 at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 1945 to Sept 27 1946

and that I last saw him alive on Sept 27 1946

Immediate cause of death: Carcinoma of Colon DURATION 18 mos

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Sigmoid Colon

Date of op. April 10 46

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Willard P. Hudson M. D. or other \_\_\_\_\_

Address Forest Hill md Date signed 9/27/46

RECEIVED

OCT 2 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 0907780

## 1. PLACE OF DEATH:

County HarfordCity or town Abingdon  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Conn. County LitchfieldCity or town Sorrington  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war. ☒

## 3. (a) FULL NAME

Augusta Rosier

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Frank Rosier

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

May 19, 1868

8. AGE:

Years

Months

Days

If less than one day

78410

hrs.

min.

9. Birthplace

Mass. U.S.A.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John Rosier

13. Birthplace

France

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Thomas C. Morgan

Address

Abingdon Md17. Transportation  
(Burial, cremation, or removal. Which?)

Date thereof

Oct 1, 1946  
(month) (day) (year)

Cemetery or crematory

Toupinus-Hill Funeral Home

Location

Sorrington Conn.

18. Funeral director

Harold K. McCombs & son

Address

Abingdon Maryland19. Oct 1  
(Date rec'd by registrar)19 46Mary M. Moulton

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Sept. 2919 46, at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 2819 46, toSept 2919 46and that I last saw him alive on Sept 2819 46

Immediate cause of death

Acute HeartFailure

DURATION

Due to

Hypertensive cardiac vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

HB Jastram MD

M. D. or other

Address

Abingdon MdDate signed Oct 1

RECEIVED  
OCT 3 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

09078

Reg. Dist. No. 180

## 1. PLACE OF DEATH:

County Harford  
 City or town Joppa  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Joppa  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Lottie Skillman

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Harry Skillman  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) Feb. 17, 1889  
 8. AGE: Years 57 Months 7 Days 1 If less than one day ..... hrs. .... min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business

12. Name John M. Frasch  
 13. Birthplace Germany  
 14. Maiden name Louise Kammerer  
 15. Birthplace Maryland

16. Informant Harry Skillman  
 Address Joppa Md

17. Burial Date thereof Sept. 22, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cokesbury  
 Location Abingdon Md.

18. Funeral director Howard K. McComas & Son  
 Address Abingdon Md.

19. Sept 22 19 46 Mae M. Moulsdale  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 19 46, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-4 19 46 to Sept 18 19 46 and that I last saw him alive on Sept 18 19 46

Immediate cause of death coronary thrombosis DURATION 1 1/2 hrs

Due to.....  
 Due to.....

Other conditions Essential hypertension Veins  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury Injured at work?

23. SIGNATURE Fred O. Hodson M. D. or other  
Edgewood, Md Address Date signed 9-18-46

RECEIVED

SEP 25 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 526

## CERTIFICATE OF DEATH

Reg. Dist. No. 09079 182

## 1. PLACE OF DEATH:

County Hartford  
 City or town Bel Air, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Hartford  
 City or town Bel Air, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War I

## 3. (a) FULL NAME

Col Sydney L Smith

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Winifred S. Smith

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept 16 - 1873

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Burgin Point, N. C.  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name John C. Smith13. Birthplace N. Y.14. Maiden name Mary B. McDonald15. Birthplace N. Y.16. Informant Mrs Winifred S. SmithAddress Bel Air, Md.17. Cremation Date thereof Sept 16 / 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory London ParkLocation Baltimore, Md18. Funeral director Dean & FosterAddress Bel Air, Md19. 9/14 19. 46 Priscilla Towood  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept 13 19 46 at 9<sup>50</sup> A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT 1 - 19 44 to Sept 13 19 46and that I last saw him alive on Sept 6 - 19 46Immediate cause of death Coronary ThrombosisDURATION Sudden death

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Metastatic Carcinoma of bones of pelvis -  
(Include pregnancy within 3 months of death)Major findings of operations Aug 1944 - Carcinoma of bladder

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Wesley P. HudsonAddress Forest Hill Md Date signed 9/13/46

M. D. or other \_\_\_\_\_

RECEIVED

SEP 17 1946

BUREAU V R

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09080

Reg. Dist. No.

182

## 1. PLACE OF DEATH:

County Harford  
 City or town Rural - Bel Air  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford  
 City or town Rural - Bel Air  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Dechory  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Samuel Allen Spicer

## 3. (b) Social Security Number

4. Sex male 5. Color or race wh 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife May Edwards Spicer

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 23, 1880

8. AGE: Years 66 Months 4 Days 7 It less than one day  
 hrs. min.

8. Birthplace Allegheny co, N.C.  
(Town, county, and state)10. Usual occupation Farming

11. Industry or business

12. Name Samuel Morgan Spicer13. Birthplace Allegheny co, N.C.14. Maiden name Emma Jender15. Birthplace Allegheny co, N.C.16. Informant Mrs May SpicerAddress Bel Air, Md17. Burial Date thereof Oct 2/1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt Zion CemeteryLocation Fountain Green Harbor Co., Md18. Funeral director Dean & JesterAddress Bel Air, Md19. 10/1 46 Priscilla Lownd  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1946 at 9:25 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1946 to Sept 30 1946and that I last saw him alive on Sept 30 1946Immediate cause of death Cerebral Hemorrhage DURATION 45 min.

Due to.....

Due to.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or otherAddress Forest Hill, Md Date signed 9/30/46

RECEIVED

OCT 4-1945

BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE REGISTRAR

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09081

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County... Harford  
 City or town... Harford  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 51 years  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hosp  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Ind County... Harford  
 City or town... Harford  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 319 Strawberry Alley  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Albert Stokes

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Dorothy S. Stokes  
 6.(c) If alive, give age 38 years  
 7. Birth date of deceased (mo., day, yr.) Dec 28-1893  
 8. AGE: Years 52 Months 8 Days 28 If less than one day  
 hrs. min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation Janitor

11. Industry or business

12. Name Dorothy Thomas

13. Birthplace Maryland

14. Maiden name Mary B. Stokes

15. Birthplace Maryland

16. Informant Dorothy R. Stokes

Address 319 Strawberry Alley

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 9/28/46  
 (month) (day) (year)

Cemetery or crematory Swan Creek Col'd Cem.

Location Swan Creek Md.

18. Funeral director Pennington & Son

Address Harford Md.

19. Sept. 28 1946 G. T. Lewis, Jr. D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 19 46 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9/25 19 46 to 9/25 19 46  
 and that I last saw him alive on 9/25 19 46

Immediate cause of death Respiratory Failure

Due to St. Broncho pneumonia

Other conditions Pose. Periton. Quen

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results St. Broncho pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dudley Phillips Md

Address Harford Mem Hosp

Date signed 9/27/46

RECEIVED

SEP 30 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 44-5

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

## 1. PLACE OF DEATH:

County Harford  
 City or town Upper x Roads  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Harford  
 City or town Upper x Roads  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mabel Florence Walker

## 3. (b) Social Security Number

-

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Wm H. Walker  
 6.(c) If alive, give age 62 years  
 7. Birth date of deceased (mo., day, yr.) July 15 1887  
 8. AGE: Years 59 Months 2 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rutledge Harford md  
 (Town, county, and state)  
 10. Usual occupation House wife

## 11. Industry or business

12. Name Wm K. Standiford  
 13. Birthplace md.  
 14. Maiden name Mary Amoss  
 15. Birthplace Fallston md.

16. Informant Wm H Walker  
 Address Fallston md.

17. Burial Burial Date thereof Oct 2, 46  
 (Burial, cremation, or removal Which?) (month) (day) (year)  
 Cemetery or crematory Friendship  
 Location Fallston md.

18. Funeral director Marion Lewis  
 Address Janethville, Md

19. Oct 2, 46 Thomas P. Brown  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30, 1946 at 10:15 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10, 1946 to Sept 25, 1946  
 and that I last saw him alive on Sept 25, 1946  
 Immediate cause of death Carcinoma of breast DURATION 1945  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations Carcinoma of Breast Aug-1946  
 Date of operation Aug-1946  
 Autopsy results no  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Dr. M. H. Bennett M. D. or other  
Baldwin Date signed 10/1/46  
 Address \_\_\_\_\_

RECEIVED  
OCT 4 1966  
BUREAU OF  
PROPERTY

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8-6)

## CERTIFICATE OF DEATH

09083

Reg. Dist. No. 18

### 1. PLACE OF DEATH:

County Harford  
City or town Fallston  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 81 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford  
City or town Fallston  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

### 3. (b) Social Security Number

Alice King Shatton  
4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

5. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18 - 1866

8. AGE: Years 81 Months 4 Days 27 If less than one day hrs. min.

9. Birthplace Fallston Harford County Md.  
(Town, county and state)

10. Usual occupation none

11. Industry or business

12. Name John Thomas Shatton

13. Birthplace Baltimore, Md.

14. Maiden name Elizabeth Amos

15. Birthplace Benson Harford County Md.

16. Informant Miss Martha Shatton

Address Fallston, Md.

17. Burial Date thereof Sept. 17, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Little Falls Friends Meeting House

Location Fallston

18. Funeral director Martin G. Hunt

Address Garrettsville, Md.

19. 90 to 46 Viocilla Lowmuth  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 19 46 at 6:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4, 19 44, to September 14, 19 46, and that I last saw her alive on September 14, 19 46

Immediate cause of death Cerebral Thrombosis DURATION 10 days

Due to

Due to

Other conditions Cerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other

Address Forest Hill, Maryland. Date signed 9/15/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 19 1946  
BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Hartford CoCity or town Bell Air, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? ✓

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md Pa CountyCity or town Chester  
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war World War I

## 3. (a) FULL NAME

Lt. Sg. Louis Maxwell WEGAT

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M6. (b) Name of husband or wife UNKNOWN7. Birth date of deceased (mo., day, yr.) Jan'y 24-1882 6. (c) If alive, give age..... years8. AGE: Years 64 Months 8 Days 25 If less than one day  
..... hrs. .... min.9. Birthplace Cleveland Ohio  
(Town, county, and state)10. Usual occupation Retired-Navy

11. Industry or business

12. Name Louis M Wegat13. Birthplace UNKNOWN14. Maiden name UNKNOWN15. Birthplace UNKNOWN16. Informant Mrs Agnes Simpson Calif.Address 6046 W. Metropolitan Plaza, Los Angeles17. Burial Date thereof Sept 20/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington Va.19. Funeral director Dean & LutzAddress Bell Air, Md19. 9/1/46 46 Priscilla Lowwood  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 18, 19 46, at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

CORONARY OCCLUSION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J. H. Ramsey M.D.Address Aberdeen, Md. Date signed 9/15/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09084



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 150

## CERTIFICATE OF DEATH

Reg. Dist. No. 09085 183

## 1. PLACE OF DEATH:

County Harford  
 City or town Janettsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 to years  
 Hospital, institution, or street address where death occurred: \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Harford  
 City or town Janettsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Amos Whittle

## 3. (b) Social Security Number

--

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Angeline R Bowman7. Birth date of deceased (mo., day, yr.) march 17 - 1871 6. (c) If alive, give age 64 years8. AGE: Years Months Days If less than one day  
75 6 1 hrs. min.9. Birthplace Janettsville Harford co md  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Jeremiah Whittle13. Birthplace not known14. Maiden name Ellen Monroe15. Birthplace not known16. Informant Angeline R. WhittleAddress Janettsville md.17. Burial Date thereof Sept 21, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brown WattersLocation Coottown Harford co md.18. Funeral director Martha SknitzAddress Janettsville md.19. Sept 21, 1946 Thomas R. Brown

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18<sup>th</sup> 1946 at 11:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1945 to Sept 18 1946 and that I last saw h.i.v. alive on Sept 16 1946Immediate cause of death Pulmonary tuberculosisDURATION 6 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles P. HoffAddress Street, Md. Date signed 9-19-46

9-19-46

RECEIVED  
SEP 26 1946  
BUREAU T C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

## CERTIFICATE OF DEATH

09086

★ Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County..... Harford  
 City or town..... Forest Hall Green  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Harford  
 City or town..... Fountain Green  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

MELVIN ROE WILLIAMS

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 2, 1946

8. AGE:

Years

Months

Days

If less than one day

4

hrs.

min.

9. Birthplace..... Fountain Green  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER

12. Name..... MELVIN BROWN

13. Birthplace

W. Va14. Maiden name..... VIRGINIA WILLIAMS

15. Birthplace

W. Va16. Informant..... Mrs Zella Williams

Address

Street H Md17. Burial  
(Burial, cremation, or removal. Which?)Date thereof..... Sept 7, 1946  
(month) (day) (year)Cemetery or crematory..... Not Given

Location

Fountain Green18. Funeral director..... Deane & Foster

Address

Belair Md19. 9/7  
(Date rec'd by registrar)19. 46 Priscilla Townsend  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6 SEPTEMBER 1946 at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 SEPT. 1946 to 6 SEPT. 1946and that I last saw him..... alive on 6 SEPT. 1946

Immediate cause of death.....

PREMATURITY

DURATION

4 DAYS

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE.....

Robert A. Barthel MD

M. D. or other

Address..... Forest Hall Md Date signed 9/7/46

RECEIVED

SEP 10 1945

BUREAU V S

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09981

## 1. PLACE OF DEATH:

County HARFORD  
 City or town ABERDEEN PROVING GROUND  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

STATION HOSPITAL, ABERDEEN PROVING GROUND

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State OHIO County .....

City or town SALEM  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. RFD # 1

(If rural, give LOCATION)

2.(a) If veteran, name war WORLD WAR II

## 3. (a) FULL NAME

FERDINAND F. WOLF

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITESINGLE

6. (b) Name of husband or wife..... None

7. Birth date of deceased (mo., day, yr.) 11 NOVEMBER 1918

8. AGE: Years Months Days If less than one day  
27 10 16 .....hrs. ....min.

9. Birthplace CUYAHOGA, OHIO

(Town, county, and state)

10. Usual occupation..... SOLDIER

11. Industry or business

12. Name CONRAD WOLF

13. Birthplace Unknown

14. Maiden name..... Unknown

15. Birthplace

16. Informant HEADQUARTERS, ORD. TRAINING CENTER

Address ABERDEEN PROVING GROUND, MARYLAND

17. Transportation Date thereof Sept 30 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mousman Vgt. Funeral Home

Location Alliance Ohio

18. Funeral director Howard K. McCreary

Address Abingdon Maryland

19. Oct. 3 1946 Nellie Wiley  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 27 SEPTEMBER 1946 at 5:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 .....19..... to .....19.....

and that I last saw h..... alive on .....19.....

Immediate cause of death LOBAR PNEUMONIA

DURATION

Due to LYMPHOMA OF STOMACH, LUNGS,  
PLEURA, SPLEEN, PANCREAS

Due to.....

Other conditions ANEMIA, SECONDARY

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results LYMPHOMA, AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE B. B. Landing 1214, M.C.  
 M. D. or other

Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 17 1946

BUREAU V. S.